



Houk Chiropractic Clinic

Confidential Patient Information

Date: _____

Northpointe Office
9720 N. Nevada
Spokane, WA 99218
(509) 464-2273

Monroe Office
3809 N. Monroe
Spokane, WA 99205
(509) 326-3795

▪ First Name: _____ Last Name: _____ MI: _____

Nickname: _____

PERSONAL INFORMATION

Address: _____

City: _____ State: _____ Zip: _____

▪ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Social Security #: _____

▪ Birth Date: _____ Age: _____ Sex: M / F

Marital Status: *M / S / D / W* Spouse's Name: _____

Your Occupation: _____ Employer's Name: _____

Work Address: _____

INSURANCE INFORMATION

Work Injury? Y / N

Motor Vehicle Collision? Y / N

▪ Personal Insurance (to be billed): _____

Card Holder's Name: _____ Card Holder's D.O.B.: _____

Card Holder's Home Phone: _____ Work Phone: _____

Insurance I.D. #: _____ Plan Name: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

▪ Is this for a particular condition Y / N **or** a wellness check-up Y / N

▪ Have you had any recent X-rays for this condition? Y / N

▪ Will there be someone able to attend with you? _____

▪ Who can we thank for referring you to our office? _____

▪ Will you be taking advantage of our webpage and downloading the paperwork? Y / N

Appt. Scheduled By: _____ Date: _____ Date of Appt.: _____

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill. If my account is turned over for collection, there will be a \$20.00 charge added to my account.

I hereby authorize physicians and staff at Houk Chiropractic Clinic to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Houk Chiropractic Clinic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks elated to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with chiropractic Care.

Soreness – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns – Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor, or a staff member at Houk Chiropractic Clinic.

Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAS, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature

Date

Patient /Legal Guardian Signature

Date

Seasonal Address Information

If you reside at a second address during part of the year, please provide the information below:

Second Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____

Check months at this address:

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec